First Health Services of Montana
Adult Intensive Outpatient Services
Continued Stay Prior Authorization Request Form

First Health Services of Montana

To transmit request information:

FAX: 1-800-639-8982

PHONE: 1-800-770-3084

Mail:

4300 Cox Road

Glen Allen, VA 23060

Start date: _____

H0046 HB	**Individual or family therapy sessions**	**by provider #_____**
	Number of Units Requested (up to 90 days):	**_____ max. 90 units**
H2014	**1:1 telephone or face to face DBT coaching & case management**	**by provider #_____**
	Number of 15-minute Units Requested (up to 90 days):	**_____ max. 90 units**
H2014 HQ	**DBT skills group sessions**	**by provider #_____**
	Number of 15-minute Units Requested (up to 90 days):	**_____ max. 130 units**

(NOTE: Services cannot be requested to start prior to the date of faxed submission or postmark)

Print or type:

PATIENT INFORMATION

Patient Name:

DOB: / / **Gender: M ☐ F ☐**

Address:

City: **State:** **Zip Code:**

Patient ID Number: **Medicaid ☐ or MHSP ☐**

PROVIDER INFORMATION

Primary Therapist's Name: **Provider Number:**

Address:

City: **State:** **Zip Code:**

Telephone Number: **Fax Number:**

Other Provider's Name: **Provider Number:**

Address:

City: **State:** **Zip Code:**

Telephone Number: **Fax Number:**

Other Provider's Name: **Provider Number:**

Address:

City: **State:** **Zip Code:**

Telephone Number: **Fax Number:**

CLINICAL INFORMATION

Date of Most Recent Clinical Assessment:

DSM-IV-TR DIAGNOSIS: **Has the DSM Diagnosis Changed since last request? Yes ☐ No ☐**

Axis I	**Code**	**Narrative**
	Code	**Narrative**
	Code	**Narrative**
Axis II	**Code**	**Narrative**
	Code	**Narrative**
Axis III		
Axis IV		
Axis V		

Current Medications:

Prescribing Physician:

Type of Medication	**Dosage**

Processing may be delayed if information submitted is illegible or incomplete

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Name -- Last: _____ First: _____

SSN: _____

Treatment History/Concurrent Services

Check any concurrent services received by this patient within the past 90 days.
Note this should also include: Any episodes of suicidal/homicidal behavior and/or behaviors that necessitated emergency intervention or temporary movement to a higher level of care.
INCLUDE DATES AND NAMES OF PROVIDERS BELOW

Type of Service		Type of Service	
Acute Psychiatric Hospital	Yes ☐ No ☐	Adult Day Treatment	Yes ☐ No ☐
State Hospital (MT or other)	Yes ☐ No ☐	Adult Group Home	Yes ☐ No ☐
Partial Hospitalization	Yes ☐ No ☐	Adult Foster Care	Yes ☐ No ☐
Crisis Stabilization	Yes ☐ No ☐	Case Management	Yes ☐ No ☐
Chemical Dependency Treatment	Yes ☐ No ☐	Medication Management	Yes ☐ No ☐
Other (Specify)	Yes ☐ No ☐		Yes ☐ No ☐

Provider Names & Dates

Current Mental Status - Summary of patient's current psychological symptoms and level of functioning:

Provide a brief summary of patient's progress in their Intensive Outpatient Treatment Program:

Treatment Plan

Provide documentation of current treatment plan, goals and measurable objectives, documentation of client's willingness to engage in treatment, and a rationale for your request for number of sessions and type of services. The treatment plan must be specifically tied to symptoms and functional difficulties.

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Name -- Last: _____ First: _____
SSN: _____
Crisis Plan
Discharge Plan (include estimated date of discharge)
Discharge Criteria/Goals: Estimated Discharge Date:
Provide a rationale for your request (based on presenting symptoms, diagnosis, level of need, etc.). <u>If this is an amended request from a previous certification, provide clear documentation as to why the previous request is being amended:</u>

I certify that I have reviewed the Clinical Management Guidelines for Intensive Outpatient Therapy Services as outlined in the First Health Provider Manual and that this patient meets these guidelines at this time.

Assessment completed by:
Title: Date:

For First Health's Use Only:

APPROVED**:** From_____ Thru_____ DENIED: From_____ Thru_____
Review Date:_____ Reviewer Signature: _____

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